APPLICATION FOR CLINICAL LABORATORY LICENSE

Division 2, Chapter 3, California Business and Professions Code

INSTRUCTIONS: Please use typewriter or print in ink. Complete both sides of this application and return with required information and required fee.

Send to: State of California, Department of Health Services
LABORATORY FIELD SERVICES
2151 Berkeley Way, Annex 12
Berkeley, California 94704–1011

1. Name of laboratory (exactly as desired on license)

2. CLIA certificate number

Laboratory location (street,number)

3. DATE
Director of lab changed on _____
Owner of lab changed on _____
New laboratory opening on _____

City	State	ZIP code	Telephone number ( )

4. State number of testing sites for this CLIA number _____. If more than one, complete form B.

5. Legal name of corporation, district or association owning laboratory: (Fictitious name permit must be on file—state name of locality where permit is filed)

6. Check type of ownership. Complete requested name and address (Section 1211 of Business and Professions Code).

❒ Individual

Name	Address

❒ Partnership (whether general or limited). Give names of all the members of the partnership.

Name	Address

❒ Corporation: State the names of the officers, directors, shareholders holding a five percent or more interest in the corporation, and any person, partnership, or corporation who or which has the responsibility to manage or conduct the day-to-day operation of the laboratory. (Use supplementary sheet if necessary.)

Name	Address

❒ Unincorporated Association

Name	Address

❒ District, city, county, or state

Name	Address

❒ Other (specify)

Name	Address

Name of laboratory

7. Director(s) of laboratory		Hours Per Week To Be Spent in this Laboratory
Name	Address	
Name	Address	
Name	Address	
Name	Address	
Name	Address	
Name	Address	
Name	Address	

8. Attach a list of tests and the test kits, methodologies, and laboratory equipment used. Form LAB 144A (8/99)

9. Complete and return Disclosure of Ownership and Control Interest Statement. Form LAB 1513 (3/99)

10. Complete and return the enclosed Laboratory Personnel Report form with this application. Form LAB 116 (3/99)

11. Is this facility in a licensed acute care hospital? ❒ Yes ❒ No

12. If this facility has a certificate of accreditation, submit proof of accreditation (e.g. copy of confirmation letter from the accrediting body).

13. Does this facility meet the definition of a Physician Office Laboratory (POL)? ❒ Yes ❒ No
(POL is owned and operated by an individual, a partnership, or professional corporation that performs tests or examinations only for patients of five or fewer physicians and surgeons or podiatrists who are shareholders, partners, or employees of the partnership or corporation. See Business and Professions Code, 1206(a)10.)

This statement must be signed by the owner or a person legally authorized to bind the owner, and the Laboratory Director.

I declare that the foregoing statements are true and correct to the best of my knowledge and belief. I declare that any statements contained in the documents submitted are true and correct to the best of my knowledge and belief and that the documents submitted are copies of the originals to the best of my knowledge and belief.

Director Signature	Print name
Title	Date
Owner Signature	Print name
Title	Date

Additional Information Requested

Please submit the name, address, and CLIA number (if known) of any out-of-state laboratory used by your laboratory. Please use additional sheet if needed.

Name	Address	CLIA number
Name	Address	CLIA number
Name	Address	CLIA number
Name	Address	CLIA number
Name	Address	CLIA number